DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTHCARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER: 07 - 11

2. STATE: Michigan

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH FINANCING ADMINISTRATION
DEPARTMENT OF HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2007

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 431, Subpart D

7. FEDERAL BUDGET IMPACT:
a. FFY 07 $ -0-
b. FFY 08 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, Section VIII, pages 1 thru 6

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D, Section VIII, pages 1 thru 8

10. SUBJECT OF AMENDMENT:
LTC Provider Appeals process

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Paul Reinhart, Director
Medical Services Administration

12. SIGNATURE OF STATE AGENCY OFFICIAL
Edward P. Kemp /sfa

13. TYPED NAME:
Paul Reinhart

14. TITLE:
Director, Medical Services Administration

15. DATE SUBMITTED:
July 31, 2007

16. RETURN TO:

Medical Services Administration
Program/Eligibility Policy Division - Federal Liaison Unit
Capitol Commons Center - 7th Floor
400 South Pine
Lansing, Michigan 48933

Attn: Nancy Bishop

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

18. DATE APPROVED:

**PLAN APPROVED – ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPE NAME:

22. TITLE:

23. REMARKS:

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***(Long-Term Care Facilities)***

VIII Appeals Procedure

The appeals procedure can be initiated by a provider upon receipt of a notice of adverse action, for an informal or formal review or hearing. Procedure I contains provisions for: 1) all classes of providers for formal hearings; 2) all classes of providers for informal reviews which pertain to such adverse action issues as cost settlement and rate determinations, and incentives; and 3) Class IV and V providers for informal reviews of audit findings, if applicable. Procedure II contains provisions for the informal review of an adverse action that is contained in the final summary of audit findings issued by the State agency. This procedure is available to Class I, II and III providers and is effective for cost reporting periods ending on or after September 30, 1987.

A. Procedure I

1. Once a notice of adverse action is issued, a provider may invoke Procedure I by submitting its application in writing to the State agency. The written request shall include an identification of the issue(s) for which resolution is being sought and a description of why the provider believes the determination on these matters is incorrect.

2. Appeals which are allowable under this plan through this procedure will be conducted in accordance with the procedures outlined in the rules, filed on March 4, 1978, as amended, and adopted into Administrative Rules, R400.3401 through R400.3424.

3. A written application for a formal hearing (that is, a hearing conducted by an administrative law judge) must be received within 30 calendar days of the date of notice of an adverse action or a final determination notice. Exceptions: 1) A written request for a formal hearing pertaining to a notification of intent to terminate shall be made in accordance with subrule 6(4) of Administrative Rule R400.3406. 2) A written application for a formal hearing following an administration conference conducted under Provision 4(c) of Procedure II shall be made in accordance with Provision 4(e) of Procedure II and 3) as otherwise provided in Section VIII.A.1 above.

B. Procedure II – Provisions for Audit Reviews and Appeals

At the election of the provider, Department of Community Health Medicaid Provider Reviews and Hearing Rules R400.3402 through R400.3403 will not apply to provider appeals of audit findings initiated by Class I, Class II and Class

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III providers of long term care for cost reporting periods ending on or after September 30, 1987. In place of these rules, the following provisions will apply.

1. Provision 1. As used in these provisions:

   a) *Adverse action* means the audit adjustments contained in the final summary of audit findings that is issued by the appropriate audit representative(s) of the department

   b) *Administration* means the Medical Services Administration of the ~~Michigan Department of Community Health~~

   c) *Administration Director* means the Director of the Medical Services Administration, Michigan Department of Community Health.

   d) *Appropriate audit representative(s)* means that individual(s) employed or contracted by the Michigan Department of Community Health to conduct audits of provider cost reports.

   e) *Days,* as used herein, refers exclusively to calendar days unless otherwise specified.

   f) *Delegate* means a person who is authorized to act on behalf of the administration director.

   g) *Department* means the Michigan Department of Community Health, its officials or agents.

   h) *Director* means the director of the Michigan Department of Community Health.

   i) *Final determination notice* means a notice of an adverse action which includes the action to be taken; the date of the proposed action; the reason for the action; the statute, rule or guideline under which the action is taken; and the right to a hearing.

   j) *Provider* means an individual, firm corporation, association, agency, institution or other legal entity which is providing, has formerly provided, or has been approved to provide, medical assistance to a recipient pursuant to the medical assistance program.

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k) *Receipt of. . .* as used herein is either on the day of personal delivery or will be presumed on the third day subsequent to the postmark date if the article of mail containing the referenced document is: deposited in Michigan in the United State mail; mailed first class; and properly addressed with postage pre-paid.

2. Provision 2. The provider must prepare a correct, complete cost report and assure that this cost report is received by the appropriate organizational entity in the administration within 5 months of the date of its fiscal year end.

3. ~~Provision 3. Audit review process:~~

a) The appropriate audit representative(s) must complete his field (desk) audit and issue a preliminary summary of audit findings to the provider within 135 days of the date of receipt of the correct, complete cost report.

b) If the provider or its representative desires to contest the findings required by Provision 3.a), the provider or its representative must respond to the appropriate audit representative(s) within 15 business days of the date of the preliminary summary of audit findings, and indicate which findings it contests.

c) If no timely request for an area office conference is made by a provider or its representative, the audited data as outlined in the preliminary summary of audit findings will be submitted for the rate determination process mentioned in Provision 4.d). The provider will be deemed to have waived its right to any further administrative processes contained in these provisions and in administrative hearing rules R400.3405 through R400.3424. The findings as outlined in the preliminary summary of audit findings will be implemented.

d) The appropriate audit representative(s) must, within 15 days of receipt of the response referenced in Provision 3.b), schedule and conduct a conference to discuss the prelirminary summary of audit findings. This conference will be called the area office conference. The provider or its representative must present the appropriate audit representative(s) with the documents and arguments it feels supports its position relative to the issue(s) it is contesting. Likewise, the appropriate audit representative(s) shall explain to the provider his/her basis for the findings which the provider is contesting.

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e) The appropriate audit representative(s) must, within 15 days of the date of the area office conference, issue a final summary of audit findings to the provider. This is the final step in the audit review process.

f) If no timely request for an administration conference is made by a provider or its representative, the audited data as outlined in the final summary of audit findings will be submitted for the rate determination process mentioned in Provision 4.d). The provider will be deemed to have waived its right to any further administrative processes contained in these provisions and in administrative hearing rules R400.3405 through R400.3424. The findings as outlined in the final summary of audit findings will be implemented.

4. Provision 4. Appeal process – administration conference

a) If the provider desires to appeal items contained in the preliminary summary of audit findings the provider must file, within 30 days from the date of the final summary of audit findings, a request with an appropriate delegate of the Administrative Tribunal. The request must detail each item in the preliminary summary of audit findings that the provider wishes to appeal.

b) The provider or its representative(s) cannot appeal field (desk) audit findings at the administration conference that it did not contest during the area office conference.

c) Upon receipt of the provider's request as detailed in Provision 4a) above, the delegate of the Medical Services Administration must schedule an administration conference. The delegate must schedule and conduct the conference, and the Medical Services Administration must issue its report of the conference and a final determination notice (pursuant to Provision 1(i) and Rule 5 (R400.3405) of the Department's rules for Medicaid provider reviews and hearings) within 45 days from the date of the provider's request as filed in accordance with Provision 4 a) above.

d) Within 30 days from the date of the final determination notice issued by the Medical Services Administration, the Medicaid agency will be required to issue the provider a prospective rate based upon the audited cost data as amended, if necessary, by the findings of the administration conference.

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e) Within 30 days of the date of the preliminary determination notice, the provider or its representative(s) may request a formal hearing before an administrative law judge. The formal hearing will be conducted in accordance with the Michigan Department of Community Health Medicaid provider reviews and hearings rules, R400.3401 and R400.3406 through R400.3424.

f) If no timely request for an administrative hearing is made by a provider or its representative(s), the provider will be deemed to have waived its rights to an administrative hearing. No further administrative appeal rights will be afforded the provider under these provisions. The action as outlined in the final determination notice will be implemented.

5. Provision 5 – In computing any period of time prescribed or allowed, the day of the act, event or default after which the designated period of time begins to run is not included. The last day of the period so computed is included, unless it is a Saturday, Sunday or legal holiday in which event the period runs until 5 pm of the next business day which is not a Saturday, Sunday or legal holiday.

C. Specific Situation Provisions for Procedure II

1. If the cost report of a provider is not filed timely (that is, in accordance with Provision 2), the State agency will have the option to distribute "late days" into any segment of the time frame for which the State agency is the responsible entity. For this purpose, "late days" means the number of calendar days that have elapsed from the day after the cost report was due through the day the cost report is accepted by the State agency as being correct and complete. The State agency will notify the provider of the date of acceptance, the number of late days the State agency has available for distribution and the number of these days, if any, the State agency has chosen to distribute to the audit process.

2. If the cost report of a provider is not correct or complete, the "clock" for the audit segment of the cycle (that is, the process that is conducted in accordance with Provision 3(a) will be stopped. The clock will be set for recommencement of the 135 day period on the day the resubmitted cost report is accepted by the State agency as being correct and complete. The State agency will notify the provider of the date of acceptance.

3. If the State agency is responsible for a delay in the procedures and either an area office conference or administration conference is in progress, or the

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potential for an area office conference or an administration conference is still open, at the beginning of the rate year that begins a year and a day after the end of the fiscal year that is being processed the provider will be given a provisional rate for the new rate year. For this purpose, "delay in the procedures" means, if applicable: 1) the State agency failed to issue the preliminary summary of audit adjustments timely (that is, in accordance with Provision 3(a) or as amended in accordance with specific situation 1); 2) the State agency failed to conduct the area office conference timely (that is, in accordance with Provision 3(d) or as amended pursuant to specific situation 1); 3) the State agency failed to issue the final summary of audit findings timely (that is, in accordance with Provision 3(e) ~~or as amended pursuant to specific situation 1); and/or 4) the State agency failed~~ to issue a final determination notice timely (that is, in accordance with Provision 4(c) or as amended pursuant to specific situation 1). The provisional rate will be established by updating the payment rate for the immediately preceding rate year with an appropriate nursing home cost factor adjustment for the new rate year. Upon the completion of the audit appeal process, an adjustment, retroactive to the beginning of the new rate year, will be made.

D. Nonappealable Elements

Elements of the reimbursement program for which an administrative remedy, if permitted for a single provider, would imply or necessitate a change in the program for all providers or for all providers in a class may not be appealed through administrative rules or provisions but may be appealed to a court of appropriate jurisdiction. These elements include, but are not limited to: 1) the determination of the selection and use of inflationary adjustors (Section IV.C.3.); 2) the principles of reimbursement and guidelines which define allowable costs (Section III.); 3) non-Medical Assistance Program issues; 4) the cost limits, unless otherwise specifically provided (Sections IV.B.2., and the appropriate subsections of IV.C.3. and IV.B.4.); and 5) the State agency determination of the allowability of items certified under this plan (until such time as an audit is completed).

E. Adjustments

If the results of an appeal require a change in a provider's rate, the change will be effected through an aggregate adjustment.